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AN ANALYSIS OF "INFORMED CONSENT"

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I. INTRODUCTION

THE late Justice Frankfurter, in a 1943 opinion, referred to the term "assumption of risk" as "an excellent illustration of the extent to which uncritical use of words bedevils the law." He wrote: "A phrase begins life as a literary expression; its felicity leads to its lazy repetition; and repetition soon establishes it as a legal formula, undiscriminatingly used to express different and sometimes contradictory ideas."[1]

An example of this phenomenon in the 1960's is the expression "informed consent." It is used most frequently in discussion of the liability of a physician to his patient. The expression has that "felicity" referred to by Justice Frankfurter. It is attractive because it seems to suggest a certain degree of sophistication and discernment on the part of the user. As its appearance in judicial opinions is relatively recent, it may also suggest that the user is familiar with the latest developments in the field. To some persons it suggests new vistas of professional liability.

The general thesis of the following discussion is that there is no basic conceptual, doctrinal or procedural innovation in the "informed consent" cases;[2] that the use of this unfortunate journalistic expression has caused confusion in judicial opinions and in some of the commentary literature;[3] that this confusion has generated litigation and will probably continue to do so; and that what is needed is a little careful thinking in the legal profession on some relatively elementary principles of the law of torts.

The source of the trouble is the failure or refusal of some members of the profession in recent times to recognize distinctions between cases involving fundamentally different wrongs. In part, this failure may be attributed to our modern system of pleading, which tolerates looseness of expression and to some degree fosters fuzzy thinking.[4] Occasionally one

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1. Tiller v. Atlantic Coast Line R.R. Co., 318 U.S. 54, 68 (1943) (concurring opinion).

2. In 1918 the Virginia Supreme Court of Appeals, in a negligence action against a physician, upheld a count which was based on the allegation "that it is the duty of a physician in the exercise of ordinary care to warn a patient of the danger of possible bad consequences of using a remedy. . . ." Hunter v. Burroughs, 123 Va. 113, 133, 96 S.E. 360, 366 (1918).

3. See Natanson v. Kline, 186 Kan. 393, 350 P.2d 1093, rehearing denied, 187 Kan. 186, 354 P.2d 670 (1960). One of the more obtuse forays in the subject is found at 75 Harv. L. Rev. 1445 (1962). Another collection of cases that rambles without benefit of any apparent guidelines of principle is Karchmer, Informed Consent: A Plaintiff's Medical Malpractice "Wonder Drug," 31 Mo. L. Rev. 29 (1966).

4. The late Edson R. Sunderland, during his long service on the faculty of the University

suspects that the vagueness of the pleading is deliberate and that uncertainty as to the exact nature of the cause of action attempted to be stated carries some tactical or other advantage for the pleader.

In part, the failure to recognize basic distinctions may be attributed to the philosophical approach to teaching torts in certain American law schools. Less stress is placed on analysis, particularly on the distinctions between categories of liability. Indeed, such distinctions are sometimes disparaged as being "legalistic," "technical" anachronisms and vestiges of the 19th century. Instead, the emphasis is centered on the "social engineering" aspects of tort law. In this framework, the character of the defendant's wrongful act is less important than are considerations of who can best afford to bear the loss that has occurred, how it can be most efficiently transferred to him, and such matters. If counsel or the judge has that orientation, it is not difficult to perceive how distinctions between causes of action of differing natures may be lost, or at least their significance not appreciated.

A desire for careful identification of the category of wrong involved is not merely an old-fashioned pedantic longing for legalistic perfection. Such identification will control the decision of a number of crucial questions in the case, such as the nature of the physician's duty to the patient, the kind of evidence required to establish the wrong, and the necessity of proof of causation and damage. These are the fighting issues in this area of litigation. If one misconceives the fundamental nature of the case, it is easy to wander off in a mishmash of generalities and catchwords that breeds the kind of intellectual chaos that has existed in this area in the past few years.

II. The Genesis of the Confusion

The story seems to start in 1957 with certain expressions found in an opinion of the California District Court of Appeals for the First District (Division 1) in *Salgo v. Leland Stanford Jr. University Board of Trustees*.[5] The case involved paralysis following an aortography procedure performed upon the plaintiff at Stanford University Hospital. The litigation had many facets, and, on appeal, at least seven issues were discussed by

of Michigan Law School, was one of the outstanding leaders in the field of procedural reform. He probably did as much or more than any other man in his time to displace the common law pleading system by code pleading statutes. During my first year on the faculty, when he was technically retired but amazingly active, it was my privilege to have numerous discussions with him. He said on one occasion, "The common law system of pleading had one great virtue; it compelled a lawyer to analyze his case before he started his law suit." One gains the impression that modern lawyers sometimes start suit without much prior analysis of the case; at least this occurs quite often in the torts field.

5. 154 Cal. App. 2d 560, 317 P.2d 170 (1957).

the court. One involved the content of an instruction on the physician's duty to the patient to disclose the dangers of aortography. The court's view of the law on the subject was stated as follows:

A physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment. Likewise the physician may not minimize the known dangers of a procedure or operation in order to induce his patient's consent. At the same time, the physician must place the welfare of his patient above all else and this very fact places him in a position in which he sometimes must choose between two alternative courses of action. One is to explain to the patient every risk attendant upon any surgical procedure or operation, no matter how remote; this may well result in alarming a patient who is already unduly apprehensive and who may as a result refuse to undertake surgery in which there is in fact minimal risk; it may also result in actually increasing the risks by reason of the physiological results of the apprehension itself. The other is to recognize that each patient presents a separate problem, that the patient's mental and emotional condition is important and in certain cases may be crucial, and that in discussing the element of risk a certain amount of discretion must be employed consistent with the full disclosure of facts necessary to an informed consent.[6]

A few months before the opinion in *Salgo* was handed down, a thoughtful article entitled *A Reappraisal of Liability for Unauthorized Medical Treatment*, by Professor Allan H. McCoid, appeared in the Minnesota Law Review.[7] It contained a comprehensive survey of pertinent cases in the United States and Canada and an evaluation of the manner in which they had been handled by the courts. At the risk of doing injustice to Professor McCoid, his thesis may be summarized as follows: The traditional assault and battery analysis, when applied to cases involving unauthorized medical treatment, is often awkward if not erroneous; the assault and battery approach should be confined to those relatively few cases in which the physician has engaged in intentional deviations from practice not intended to be beneficial to the patient; other cases ought to be tried and decided on other principles. His conclusion is:

The author concludes that the trial and decision of these unauthorized operation cases would be greatly improved in terms of consistency of theory and appropriateness of liability if there were a single basis for liability in all malpractice cases, other than the occasional instance of an actual assault and battery in the sense of an intentional deviation from practice which does not tend to be beneficial to the patient. The basis of liability should be deviation from the standard of conduct of a reasonable and prudent doctor of the same school of practice as the defendant under similar circumstances. The author believes that under such a standard the patient will be properly protected by the medical profession's own recognition of its obligation to maintain its standards. One particular obligation which the law may properly exact or impose, however, is the obligation of a doctor to make a reasonable disclosure to the patient

6. Id. at 578, 317 P.2d at 181.
7. 41 Minn. L. Rev. 381 (1957).

of the nature of his illness or infirmity, the nature of the treatment proposed and the danger of using such treatment or alternative treatment, and then permit the patient to decide whether to submit to the treatment or not. To overcome any difficulties of proof, the law may also properly create a presumption that where the patient has not given express consent to the operation or treatment, there has been a deviation from the standard of proper medical care, which presumption will impose upon the doctor the onus of coming forward with justification of his conduct by the use of qualified medical evidence.[8]

The *Salgo* opinion and the McCoid article set the stage for the next episode. It consisted of two opinions by the Supreme Court of Kansas and one by the Supreme Court of Missouri. The Kansas opinions were in the case of *Natanson v. Kline*.[9] The first opinion was issued April 9, 1960. The case was simple. Irma Natanson, suffering from cancer of the breast, had undergone a radical left mastectomy. At the suggestion of the surgeon who performed that operation she engaged Doctor John R. Kline for radiation therapy to the site of the mastectomy and surrounding areas. Doctor Kline was head of the radiology department at St. Francis Hospital in Wichita. The therapy was by radioactive cobalt. When it was over, Mrs. Natanson had suffered a severe injury to the skin, cartilage and bone of the chest.

In the suit that followed, plaintiff alleged that defendant Kline was negligent in two general respects, one in the administration of the therapy (8 specific particulars) and the other in failing to warn plaintiff that the course of treatment involved great risk of bodily injury or death. The case was submitted to the jury, which found that defendant Kline was not guilty of any act of negligence proximately causing the plaintiff's injury. On appeal from judgment on the verdict, the supreme court acknowledged that the state of the record was such that the verdict was warranted if the jury had been properly instructed. The attention of the court was therefore on the instructions given at the trial.

On the point of the defendant's negligence in failing to warn plaintiff, the evidence was conflicting. There was some evidence tending to show that Mrs. Natanson fully understood the dangers and risks of the treatment. There was also evidence tending to show that Doctor Kline had not told her anything about the dangers and risks of the treatment she was about to undergo. Doctor Kline was unable to remember exactly what he had said to her, and there was nothing in the record that suggested that he had given any warning. The testimony of plaintiff and her husband was that Kline had not made any statements to them in the nature of a warning.

The trial judge refused plaintiff's request for an instruction that if the

8. Id. at 434.

9. 186 Kan. 393, 350 P.2d 1093, rehearing denied, 187 Kan. 186, 354 P.2d 670 (1960).

jury found that Kline knew that the treatment involved hazard or danger and did not advise plaintiff thereof, he was guilty of negligence. The supreme court held that while the requested instruction was "too broad," the trial court should have given *some* instruction on the subject. In stating the procedure to be followed on retrial, the court said:

> [T]he first issue for the jury to determine should be whether the administration of cobalt irradiation treatment was given with the informed consent of the patient, and if it was not, the physician who failed in his legal obligation is guilty of malpractice no matter how skillfully the treatment may have been administered, and the jury should determine the damages arising from the cobalt irradiation treatment. If the jury should find that informed consent was given by the patient for such treatment, the jury should next determine whether proper skill was used in administering the treatment.[10]

This decision and mandate would probably not have attracted special attention either in the medical or legal profession, had not the court accompanied it with a rather discursive opinion which purported to review various legal aspects of "informed consent" but which seemed to reflect an alarming confusion of ideas.

After appropriating some of the language used in Professor McCoid's article,[11] the court cited three cases it deemed pertinent.[12] One was an assault and battery case and two appeared to be negligence cases. The court then made the following statement:

> The conclusion to be drawn from the foregoing cases is that where the physician or surgeon has *affimatively misrepresented* the nature of the operation *or* has *failed to point out* the probable consequences of the course of treatment, he may be subjected *to a claim of unauthorized treatment.*[13]

These words suggested assault and battery. The court then referred to a privilege that might be recognized in some cases on therapeutic grounds to withhold diagnosis of a fatal disease (which was not an issue in the case before it), and then stated: "But in the ordinary case there would appear to be no such warrant for suppressing facts and the physician should make a substantial disclosure to the patient prior to the treatment or risk liability *in tort.*"[14]

Still further in the opinion, after additional discussion of cases, the court made the following statement:

> In considering the obligation of a physician to disclose and explain to the patient in

10. Id. at 411, 350 P.2d at 1107.

11. Compare id. at 401-02, 350 P.2d at 1100, with McCoid, A Reappraisal of Liability for Unauthorized Medical Treatment, 41 Minn. L. Rev. 381, 424 (1957).

12. 186 Kan. at 404-05, 350 P.2d at 1102. The cited cases are Lester v. Aetna Cas. & Sur. Co., 240 F.2d 676 (5th Cir. 1957); Bang v. Charles T. Miller Hosp., 251 Minn. 427, 88 N.W.2d 186 (1958); Kenny v. Lockwood [1932] 1 D.L.R. 507 (1931).

13. 186 Kan. at 406, 350 P.2d at 1103 (emphasis added).

14. Id. (emphasis added).

language as simple as necessary the nature of the ailment, the nature of the proposed treatment, the probability of success or of alternatives, and perhaps the risks of unfortunate results and unforeseen conditions within the body, we do not think the administration of such an obligation, by imposing liability *for malpractice* if the treatment were administered without such explanation where explanation could reasonably be made, presents any insurmountable obstacles.[15]

Thus the court in rapid succession referred to liability for "unauthorized treatment," liability "in tort," and liability *"for malpractice."* Furthermore, in describing the nature of the disclosure required to avoid liability, the court used multiple expressions. At one point it suggested that the rule requires "substantial disclosure;"[16] at another "reasonable disclosure,"[17] and at another "full disclosure of the facts necessary to insure an informed consent."[18] And finally, to climax the discussion, it made the following statement:

How the physician may best discharge his obligation to the patient in this difficult situation involves primarily a question of medical judgment. So long as the disclosure is sufficient to assure an informed consent, the physician's choice of plausible courses should not be called into question if it appears, all circumstances considered, that the physician was motivated only by the patient's best therapeutic interests and he proceeded as competent medical men would have done in a similar situation.[19]

It is not surprising that the opinion caused questions to arise in the minds of counsel. Within a short time a motion for rehearing was made, supported by the Kansas Medical Society, which was given permission to file a brief *amicus curiae*. The motion was denied, but the court handed down another opinion because "this is a case of first impression in Kansas and one establishing judicial precedent of the highest importance to the medical profession . . . ."[20] The motion for rehearing "charged that the court has confused a malpractice suit, where negligence is an essential element, with an assault and battery case, where negligence is not an essential element, thereby giving rise to a hybrid action which is neither one of negligence nor one of assault and battery, but may be a combination of the two."[21]

15. Id. at 411, 350 P.2d at 1106 (emphasis added).
16. Id. at 406, 350 P.2d at 1103.
17. Id. at 410, 350 P.2d at 1106.
18. Id. at 410, 350 P.2d at 1107.
19. Id. at 409-10, 350 P.2d at 1106.
20. 187 Kan. at 187, 354 P.2d at 671.
21. Id. This charge was not entirely without merit. See the careful analysis of the opinion in Note, Duty of Doctor to Inform Patient of Risks of Treatment: Battery or Negligence, 34 S. Cal. L. Rev. 217 (1961). However, it apparently nettled Justice Schroeder. In the opening part of his second opinion, he wrote: "Perhaps in preoccupation over the legal obligation of the physician to his patient, the court has not adequately emphasized procedural aspects of the case, or reiterated fundamental doctrines in the law of

In response to this charge the court emphasized that the case was pleaded on a negligence theory, that one of the allegations of negligence was that defendant had failed to warn plaintiff that the course of treatment involved great risk of bodily injury or death, that defendant had pleaded assumption of risk, and that defendant was fully aware that informed consent of the patient to the hazards of the treatment was an issue of fact in the case.

The opinion then goes on to state that under the facts and circumstances presented by the record

> appellant was entitled to some explanation concerning the risks and hazards inherent in the administration of cobalt irradiation treatment . . . . The appellant was entitled to a reasonable disclosure by Doctor Kline so that she could intelligently decide whether to take the cobalt irradiation treatment and assume the risks inherent therein, or in the alternative to decline this form of precautionary treatment and take a chance that the cancerous condition in her left breast had not spread beyond the lesion itself which had been removed by surgery.[22]

After pointing out that the evidence showed that Doctor Kline gave appellant no explanation whatever, the court wrote: "On this state of the record Doctor Kline failed in his legal duty to make a reasonable disclosure to the appellant who was his patient *as a matter of law*."[23] The court then pointed out that under some circumstances failure to make any disclosure to a patient might be justified where such practice is established by expert testimony to be in accordance with that of a reasonable medical practitioner under the same or similar circumstances, but that in this case no necessity existed to produce medical testimony to show that the failure of Doctor Kline to give any explanation or make any disclosure was contrary to accepted medical practice. The court distinguished the issue of whether Doctor Kline's failure to give an explanation was a cause of the injury, pointing out that if the jury had found that Mrs. Natanson was aware of the hazards of irradiation therapy there would be no causal relationship.[24]

The value of the second opinion is that it made it clear that the court's intention was to decide a negligence case and not to impose liability in assault and battery or to create a hybrid cause of action. The uncertainties

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negligence sufficiently to completely avoid efforts to misconstrue the opinion." 187 Kan. at 187, 354 P.2d at 671. At the end of the opinion the following appears: "As always, an effort is made by the court to present an opinion in logical sequence, so that consideration of subsequent issues is dependent upon the disposition of issues previously determined, and if opinions are analyzed in this manner misinterpretations will be minimized." Id. at 191, 354 P.2d at 674.

22. Id. at 189, 354 P.2d at 672.

23. Id., 354 P.2d at 673.

24. Id. at 190, 354 P.2d at 673. See p. 662, infra.

remaining after the second opinion could be said to be of the kind that must of necessity be worked out on a case by case basis.[25]

The Missouri decision which contributed to the confusion, *Mitchell v. Robinson*,[26] was handed down two days after the first opinion in *Natanson*. It involved a claim by a patient against his physician (a psychiatrist) for fractured vertebrae suffered during an insulin shock treatment which had been part of a program of treatment extending over a period of time. One of the bases of his action was that he had not been told of the hazards connected with this type of treatment. The Missouri Supreme Court recognized a duty on the part of a physician to advise the patient of collateral hazards in connection with a proposed medical procedure. The defendants claimed that they had told the patient about the hazards attendant upon shock therapy; thus there was a clear issue of fact as to whether defendants had or had not told him. All that the court held was that this was a question for the jury. "So in this case, the plaintiff explicitly denying and the doctors affirming that they had advised the plaintiff of the hazards of shock therapy, a fact issue was presented upon which there was no necessity for expert medical testimony."[27]

Unfortunately, however, just as the first opinion in *Natanson*,[28] the *Mitchell* opinion went on to attempt to make a comprehensive statement of the law, and in the extensive dictum there are several indications of confusion as to principles and authorities. In referring to the duty of a physician to make a reasonable disclosure of the hazards attached to a particular procedure, the court cites as its authority a Minnesota case, *Mohr v. Williams*.[29] But *Mohr* was one of the earliest assault and battery cases in the United States. The court also quoted with approval some of the excerpts from Professor McCoid's article, referred to in the discussion of *Natanson*. Such reference would suggest that the writer of the opinion was thinking in terms of "malpractice" (negligence) rather than assault and battery. But the most startling language appears in that paragraph in which it is suggested that expert evidence is not necessary to establish whether or not a doctor has complied with his duty to advise the patient of the hazards involved. It is doubtful that the court meant any more than that when plaintiff says he was not advised and defendants say he was, the jury may decide which testimony to believe without the aid of experts. But the terse phrasing of the thought in the opinion could be interpreted

25. The manner in which the Kansas Supreme Court has done this is discussed at pp. 662-64, infra.

26. 334 S.W.2d 11 (Mo. 1960), aff'd, 360 S.W.2d 673 (Mo. 1962).

27. Id. at 16. On re-trial of the case it was found that defendants had advised the patient of the hazards. 360 S.W.2d at 673.

28. 186 Kan. 393, 350 P.2d 1093 (1960).

29. 95 Minn. 261, 104 N.W. 12 (1905). The case was cited in 334 S.W.2d at 15.

to mean that in "informed consent" cases expert evidence was not needed at all, even as to what hazards must be disclosed. That it led to this kind of thinking on the part of some lawyers is evidenced by the case of *Aiken v. Clary*,[30] discussed below, in which the Missouri Supreme Court reconsidered this aspect of the *Mitchell* opinion.

At this stage in the history of the subject, two annotations appeared which probably had the effect of intensifying the confusion in the field. One was a discussion in the NACCA Law Journal[31] which annotated the *Natanson* and *Mitchell* cases. The annotation contains extensive citation of other cases, but it jumbles the unauthorized operation cases and the misrepresentation cases in such a fashion that a busy lawyer reading the annotation in his office could easily get the idea that in a case of uninformed consent, liability for assault and battery is automatic. For example, at one point the writer says, referring to the *Natanson* and *Mitchell* cases,

> In effect, they declare that for the patient's consent to protect the physician from a charge of professional negligence, it must be an *"informed"* consent. An uninformed consent is as meaningless as one induced by misrepresentation. Breach by the physician of his affirmative duty to inform the patient of risks inherent in proposed treatment vitiates the patient's consent, exposing the physician to liability for negligence, regardless of the skill with which the treatment is administered. . . .
>
> It is settled that, in the absence of an emergency, adults of sound mind are entitled to determine whether their bodies shall be touched, by whom they shall be touched, and for what purposes they shall be touched. In other words, the physician-patient relationship is deemed consensual, and physicians are liable for unauthorized treatment, dealt with as an *intentional tort*, where treatment is rendered without the consent, express or implied, of the patient.[32]

This passage is followed by an extensive citation of assault and battery cases.

In the next subdivision of the article it is asserted that the result of the *Natanson* and *Mitchell* cases "receives analogical support from a line of cases holding the physician liable for intentional tort where the patient's consent is induced by express misrepresentations. If the doctor misrepresents the nature of the proposed treatment or the risks involved, such misstatements vitiate the patient's consent, leaving the doctor vulnerable to a trespass action."[33]

Whether the writer intended it or not, a reader of this annotation might very well conclude that a physician who breached his duty to disclose to a patient the risks of a procedure he was planning to undertake would

30. 396 S.W.2d 668 (Mo. 1965).
31. 26-27 NACCA L.J. 134 (1960-61).
32. Id. at 137-38 (emphasis added).
33. Id. at 139.

expose himself to an assault and battery claim. It is true that in the annotation the term "negligence" appears several times, but its importance is significantly underplayed.

Similar confusion appears in an A.L.R. annotation on the subject published in 1961.[34] Cases of unauthorized treatment were mingled indiscriminately with cases involving negligence and no attempt was made to make a careful distinction between the nature of the wrongs involved.

As a result of the foregoing writings, many lawyers in the country in 1961 could discern expanded possibilities of actions based on a violation of the so-called informed consent rule. Not only did it appear to open up a new basis of professional liability, but, even more important, it appeared to be one that could be imposed without the necessity of expert medical testimony. The difficulty of securing expert medical testimony has long been a source of unhappiness among lawyers seeking to impose professional liability for negligence upon physicians. The informed consent route may well have appeared to some to be the path out of the wilderness.[35]

III. Applicable Principles

Let us start by identifying some elementary tort doctrines. The legal wrong conventionally called "battery" or "assault and battery" consists of an unpermitted touching of the person of another; by definition a touching is not tortious if there has been consent to it by the one touched. Consent can be rendered nugatory under some circumstances. One of these circumstances is inducement of the consent by a certain kind of misrepresentation. Not every misrepresentation will have this vitiating effect. In order to negate consent the misrepresentation must relate to the nature and character of the touching. If it does, the touching is tortious (a battery) because it is no longer with the consent of the one touched.[36] Misrepresentation that does not relate to the nature and character of the touching but merely concerns some collateral matter does not have the fatal effect. The classic example is given as illustration one to section 57 of the Restatement (Second) of Torts: "A, to induce B to submit to intimate familiarities, offers her a paper which A represents to be a twenty dollar bill but which he knows to be counterfeit. B, believing

34. Annot., 79 A.L.R.2d 1028 (1961).

35. See, e.g., 109 U. Pa. L. Rev. 768, 771 nn.18-19 (1961). This note, in contrast to most of the writing at the time, envisioned some of the problems that were likely to develop as a result of the Natanson and Mitchell opinions.

36. Hobbs v. Kizer, 236 F. 681 (8th Cir. 1916) (abortion operation misrepresented); Bowman v. Home Life Ins. Co., 243 F.2d 331 (3d Cir. 1957) (insurance man misrepresented himself as a physician and made a physical examination of female applicant); cf. People v. Steinberg, 190 Misc. 413, 73 N.Y.S.2d 475 (Magis. Ct. N.Y.C. 1947) (smallpox vaccination with water misrepresented to be serum).

the paper to be a genuine bill, submits. A is not liable to B for battery."

Similarly, in *Martin v. Carbide & Carbon Chemicals Corporation*,[37] plaintiff was examined by a physician who represented that he was duly licensed to practice medicine in Tennessee. In fact, he was not so licensed. It was claimed that because of the misrepresentation of his status as a licensed physician the touching of plaintiff, to which she had consented, was unlawful (tortious) and constituted an assault and battery. A demurrer to the declaration was sustained.[38]

Let me illustrate the thought by contrasting two modern cases involving physicians' professional liability. In *Bang v. Charles T. Miller Hospital*,[39] plaintiff submitted to a prostate operation, a necessary part of which involved the severance and tying off of the spermatic cords. Defendant physician could not recall having told him about the tying procedure. The action was for "assault or unauthorized operation." The lower court dismissed the action. The Supreme Court of Minnesota reversed and granted a new trial, holding that a jury question was presented as to whether plaintiff consented to the severance of his spermatic cords. Here it would seem we have a clear case in which, if the jury believed the testimony of plaintiff, there was a misrepresentation of the nature and character of the touching; it was done by failure to disclose when there was an obligation to speak because of the physician-patient relationship. This is *not* a case of failure to disclose a risk that may or may not arise in the course of the operation, although occasionally it has been so interpreted;[40] it is simply misrepresentation by silence as to a very material and important aspect of the nature and character of the medical procedure to be applied. Thus any supposed consent is vitiated, and there is a plain unpermitted touching or battery of the plaintiff.

On the other hand, the *Mitchell* case, in the writer's view, is quite different. The plaintiff submitted to treatment by defendant physician involving "electro-shock and insulin sub-coma therapy" in the course of which he suffered a convulsion and fracture of three vertebrae. It was established that one of the unpredictable results of insulin shock is convulsion in which there is a substantial risk of fractured vertebrae, legs and similar injuries. There was no evidence of negligence in the diagnosis or the administration of treatment. In the opinion of the court, the question was whether "the doctors owed their patient in possession of his faculties the duty to inform him generally of the possible serious collateral hazards; and . . . there was a submissible fact issue of whether

37. 184 Tenn. 166, 197 S.W.2d 798 (1946).

38. See also Oberlin v. Upson, 84 Ohio St. 111, 95 N.E. 511 (1911).

39. 251 Minn. 427, 88 N.W.2d 186 (1958).

40. W. Prosser, Torts 107 (3d Ed. 1964).

the doctors were negligent in failing to inform him of the dangers of shock therapy."[41]

It is submitted that the difference between the two foregoing cases is fundamental. In *Bang*, plaintiff thought he was going to be touched in a certain way (operation on his prostate gland, possibly surgery on the bladder) but was subjected to a touching of a substantially different character (severance of spermatic cords). In *Mitchell*, plaintiff thought he was going to be touched in a certain way (insulin injection). He *was* touched in *exactly* that way, but there was a harmful result arising from a collateral risk he had not been warned about. The fundamental point is not what name we give to the two categories of cases as long as what we call them depicts two basically different wrongs which call for quite different treatment by the courts and quite different self-protective steps to be taken by the physician. It is fatal to clear understanding to intermingle the two under some broad heading such as "malpractice" or to state that both involve "informed consent." For purposes of this discussion I will refer to the first type of case (*Bang*) as a "battery"[42] and to the second type of case (*Mitchell*) as "medical negligence."[43]

It should be emphasized again that much more than a mere technical distinction is involved. Our concern is with fundamental, practical differences that may affect the pivotal issues in the cause of action. We now turn to an anlysis of these practical consequences.

IV. Practical Differences

A. *Nature of Plaintiff's Right and Defendant's Duty*

1. Battery Cases

It is clear in the battery cases that a patient has virtually an absolute right to be free from touchings of a substantially different nature and character from those to which he has consented. It is the patient's prerogative to accept medical treatment or to take his chances of living without it. A long line of authority recognizes this right. As was stated in one of the leading opinions by Chief Judge Cardozo: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent, commits an assault, for which he is liable in damages."[44]

41. 334 S.W.2d at 19.

42. I share Professor McCoid's distaste for the term, but its use here will underscore the thrust of this article.

43. This term seems well suited to describe the nature of the wrongful act involved.

44. Schloendorff v. Society of The New York Hosp., 211 N.Y. 125, 129-30, 105 N.E. 92, 93 (1914). Probably the leading case is Mohr v. Williams, 95 Minn. 261, 104 N.W. 12 (1905). The successors to these cases are legion. In a 1965 Illinois case it was held that under proper

To this general principle there are only a few limited exceptions, none of which is relevant here.

Conversely, it is clear that the physician has a fiduciary relationship to his patient and owes an absolute obligation never to mislead the patient by words or silence as to the nature and character of the medical procedure he proposes to undertake.[45] Despite occasional complaints, this duty does not seem to be unduly burdensome. It requires only that the physician speak plainly in the patient's language. Little sympathy is evoked by the occasional assertion that the nature and character of medical procedures cannot be explained without the use of highly technical language. Indeed, the use of technical terminology may embody considerable danger. A striking case in point involved a mastectomy. Defendant surgeon examined plaintiff's breast, found danger signals and recommended a test. According to plaintiff's testimony, defendant called the hospital in her presence and made reference to the removal of a breast. Plaintiff told the doctor that he was not to remove her breast, and he said he had no intention of doing so. When plaintiff reached the hospital she signed a form giving consent to a "mastectomy." Plaintiff later testified she didn't know what the word meant. Later that same day she again told defendant he was to make a test only and not remove the breast. When plaintiff emerged from anesthesia, the breast had been removed. Plaintiff sued, basing one count of her claim on the theory that defendant had performed the operation without her consent. The trial court granted a motion to dismiss. On appeal the dismissal was reversed. The court held that there was a jury question as to whether plaintiff "had withdrawn her consent," thus avoiding the question whether the consent was ever valid at all. If there had been no conversation after the consent was signed, however, the question of original validity would have been presented and could easily have been decided in plaintiff's favor.[46]

An illustration of how this result might occur is found in *Gray v. Grunnagle*.[47] The patient submitted to what he was told would be an "exploratory operation." He understood this to mean that an incision would be made in his spinal column solely for the purpose of diagnosis, that when diagnosis was complete no effort would be made at corrective surgery but that he would be sewn up and in due course advised of the nature of the illness, and that he could then determine whether he wanted to undergo the corrective procedures. To the physicians, however, the term "explora-

circumstances this right was protected by the Constitution of the United States. In re Estate of Brooks, 32 Ill. 2d 361, 205 N.E.2d 435 (1965).

45. Woods v. Brumlop, 71 N.M. 221, 377 P.2d 520 (1962).

46. Corn v. French, 71 Nev. 280, 289 P.2d 173 (1955).

47. 423 Pa. 144, 223 A.2d 663 (1966).

tory operation" meant that an incision would be made at the appropriate part of the spinal column and an effort made to identify the source of trouble, and that, if identified, every effort would then be made to eliminate or correct the pathology, or alleviate the symptoms. An attempted corrective procedure was performed followed by injurious results. Plaintiff's complaint embraced both a theory of medical negligence and a theory of medical procedure without consent. The jury rendered a verdict for $80,000 for plaintiff, but the lower court gave judgment for defendant notwithstanding the verdict. This action was reversed on appeal and judgment entered on the verdict. Although the evidence did not justify a finding of medical negligence, it did justify a finding that the procedure had been done without the consent of the patient. The decision was reached because of the patient's misunderstanding of the terminology used in securing his consent, despite the broad terms of a written consent he had signed upon entering the hospital.

The use of vague and ambiguous language may bring similar consequences. In *Paulsen v. Gundersen*,[48] plaintiff had been receiving treatment for ear trouble and was advised to have an operation. When he asked about its seriousness, he was told that it would be a "simple" mastoid operation. He consented to it. The surgeon performed a "radical" mastoid operation which was followed by loss of hearing and paralysis of part of plaintiff's face. The action was based in part on the theory that the operation had been performed without plaintiff's consent. The Wisconsin Supreme Court held that the evidence warranted submission to the jury of the question whether defendant caused the radical mastoid operation to be performed on the plaintiff without his consent and that, if so, liability would follow.

Wall v. Brim[49] presents a variation of the general theme involving a failure to disclose. Plaintiff underwent a procedure involving an incision in the neck just under and back of the ear for removal of a cyst. When it was finished she had suffered a serious injury which caused considerable facial disfigurement with disability of her mouth, tongue and eyes. Plaintiff had been told by the surgeon before surgery that it was a "very simple operation" which would not take more than five or ten minutes and the cyst could be pulled out "like hulling a pea out of a pod." After the incision was made, the surgeon discovered that the cyst was deeply embedded and in close proximity to the facial nerve. He continued with the operation without any disclosure of these facts to plaintiff who was fully conscious, the operation being performed under a local anestheic. Plaintiff sued on a negligence theory. The jury verdict was for plaintiff and from

48. 218 Wis. 578, 260 N.W. 448 (1935).

49. 138 F.2d 478 (5th Cir. 1943), aff'd, 145 F.2d 492 (1944).

judgment thereon defendant appealed. The Fifth Circuit Court of Appeals held that there was insufficient evidence to establish negligence because under the applicable law (Georgia) expert evidence was required and had not been adduced. However, the evidence suggested what appeared to be an operation without the consent of plaintiff, and the case was remanded for trial and development on that theory. The court's reasoning was that the surgeon, having previously described the operation as a simple one and then having discovered that it was a complicated and different one, had a duty so to advise plaintiff, particularly as she was conscious at the time. While his failure to do so would not support a negligence action, it could support an action for unpermitted operation.

The foregoing cases seem to demonstrate that the courts recognize a clear and simple right on the part of an individual not to be misled as to the nature and character of the intended touching to which he is being asked to consent, whether that misleading is by omission to speak, by overt misstatement, or by use of ambiguous language or technical terms. Accordingly, the physician has a clear and simple duty not to mislead the patient whether by silence, misinformation or ambiguity.

2. Medical Negligence Cases

When the case involves no substantial misunderstanding of the nature and character of the touching, but plaintiff claims he was not fully or correctly informed as to collateral hazards attendant upon the procedure, the judicial approach is quite different from that found in battery cases. Here defendant-physician's obligation and plaintiff-patient's corresponding right is less certain in nature, more flexible in character and subject to considerable variation. While it is often stated as a general proposition that the patient has the right to be advised of collateral hazards and the physician has the duty so to advise him, most cases have recognized, starting with *Salgo*,[50] that this obligation is not rigid and cannot be prescribed with specificity. It is only a part of the broad obligation of the physician to use reasonable care, but as any sophisticated person knows, the elasticity in that concept is more than negligible.

It is enlightening to examine briefly some factors that impress courts in shaping plaintiff's right and defendant's duty. While all factors cannot be identified because they are as varied as human disease and illness, one can discern in the opinions certain recurring elements to which the courts seem to ascribe importance.

One consideration often mentioned is whether the case is an emergency requiring immediate treatment. This aspect usually appears in a negative fashion; i.e., in buttressing the conclusion that defendant owed a duty to

50. 154 Cal. App. 2d 560, 578, 317 P.2d 170, 181 (1957).

disclose collateral hazards, the court emphasizes that no emergency made it impractical to perform the duty. For example, in *Bowers v. Talmage*,[51] the claim was that parents had not been warned of a hazard to their nine-year-old child from an arteriogram, an exploratory surgical process. The procedure was considered dangerous since three percent of the cases had injurious results. It caused partial paralysis of the boy. In holding that it was error to direct a verdict for defendant, the court emphasized that there was no emergency.

Similarly a case in which plaintiff suffered dermatitis as a result of injections of gold compound by defendant in treatment for rheumatoid arthritis, one claim was that there had not been sufficient advice of the hazards incident to use of gold. The court wrote, "We are of the opinion that, under the facts and circumstances disclosed by this record, *including the fact that no emergency existed*, defendant was obligated to make a reasonable disclosure to his patient of the known dangers which were incident to or possible in the proposed use of gold. . . ."[52]

Indeed, in *Natanson* (second opinion)[53] and *Mitchell*,[54] in partial explanation of the decision that a duty of disclosure existed, each court stressed that no immediate medical action was necessary. The Kansas Court said, "There was no emergency calling for immediate attention,"[55] and the Missouri Court said, "There was no emergency here, it was not even claimed that Mitchell was critically or dangerously ill and that immediate spectacular treatment was imperative."[56] This is not to say that if there is an emergency no duty of disclosure exists. What is suggested is that the absence of emergency is a circumstance likely to impress a court in determining the extent of the physician's obligation.

A second factor, and perhaps the one most frequently referred to by courts in delineating the physician's duty, is the danger of alarming the patient or causing other adverse psychological effects on him. The *Salgo* opinion,[57] in its initial description of the duty, showed an understanding that under some circumstances a reference to collateral hazards may increase the risk to the patient because of the emotional consequences. The *Natanson* case approved the *Salgo* language and recognized (at least in the second opinion) that a situation might exist in which the duty to refer to collateral hazards would be minimal.[58]

51. 159 So. 2d 888 (Fla. 1963).

52. DiRosse v. Wein, 24 App. Div. 2d 510, 261 N.Y.S.2d 623, 624 (mem.) (2d Dep't 1965).

53. 187 Kan. 186, 354 P.2d 670 (1960).

54. 334 S.W.2d 11, 18-19 (Mo. 1960), aff'd, 360 S.W.2d 673 (Mo. 1962).

55. 187 Kan. at 189, 354 P.2d at 672.

56. 334 S.W.2d at 18-19.

57. 154 Cal. App. 2d at 560, 317 P.2d at 170. See text accompanying note 6 supra.

58. 187 Kan. at 189, 354 P.2d at 673.

In a case involving hepatitis and jaundice allegedly resulting from injections of gold compound, a dismissal of the action was affirmed. The court was substantially influenced by medical testimony to the effect "that the judgment of the individual doctor had to be exercised in the light of the mental and psychosomatic make-up of the patient in advising of the risk involved. . . ."[59]

In a suit involving injury to throat nerves during a thyroidectomy, on the question whether the patient had been sufficiently advised of that hazard, the court said: "Doctors frequently tailor the extent of their pre-operative warnings to the particular patient, and with this I can find no fault. Not only is much of the risk of a technical nature beyond the patient's understanding, but the anxiety, apprehension, and fear generated by a full disclosure thereof may have a very detrimental effect on some patients."[60]

Another case of this kind involved injury to recurrent laryngeal nerves during thyroidectomy. While recognizing the existence of a general duty to disclose hazards, the court pointed out that the patient had been advised that she faced a "serious operation" and that it was "not done without risks." The court continued: "Difficulty arises in attempting to state any hard and fast rule as to the extent of the disclosure required. The doctor's primary duty is to do what is best for the patient. Any conflict between this duty and that of a frightening disclosure ordinarily should be resolved in favor of the primary duty."[61]

A third factor that influences the decision as to whether there is a duty to disclose collateral dangers is the likelihood that the danger will materialize. The greater the frequency of injury from it, the greater the obligation of the physician to mention it and vice-versa. For example, one case involved abdominal infection following an operation. In finding that judgment was properly entered for defendant, the court said:

> In the instant case we are not dealing with a known existing condition but, rather, with a mere possibility that infection might follow the operation. No claim is made that defendant Young had knowledge, or believed, that such would be the case. The question presented is in substance whether a physician and surgeon before operating should advise the patient of all *possible* results. Whether such should be done would seem to be a matter to be determined with reference to the general practice customarily followed by the medical profession in the locality.[62]

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59. Woods v. Pommerening, 44 Wash. 2d 867, 871, 271 P.2d 705, 707 (1954).

60. Roberts v. Wood, 206 F. Supp. 579, 583 (S.D. Ala. 1962).

61. Watson v. Clutts, 262 N.C. 153, 159, 136 S.E.2d 617, 621 (1964). See also Sharp v. Pugh, 270 N.C. 598, 155 S.E.2d 108 (1967), in which the North Carolina Supreme Court recognized the duty of a physician to warn of dangers attendant upon use of chloromycetin, but refrained from attempting to define the extent and limits of the duty.

62. Roberts v. Young, 369 Mich. 133, 139-40, 119 N.W.2d 627, 630 (1963).

Similarly in *Bowers v. Talmage*,[63] in which the exploratory arteriogram was performed, the court took into account the fact that death, paralysis or serious injury resulted in three percent of the cases, a level of danger deemed relatively high. It was held error to dismiss the action.

In *Fischer v. Wilmington General Hospital*[64] the relatively low incidence of the collateral hazard was relied on, *inter alia*, to warrant a finding of no duty to disclose. Plaintiff had experienced an incomplete abortion and had been bleeding. Defendant had 500 cc's of whole blood transfused to her, from which she contracted hepatitis. Her action was based largely on the ground that she had not been warned that hepatitis was a hazard of blood transfusion. Defendant's affidavits showed that the risk of transmitting hepatitis in a transfusion of whole blood was unavoidable but it was slight because the disease occurs in less than one percent of such transfusions. The court held defendant did not have a duty to advise plaintiff of this risk, basing its decision in part on the infrequency of its incidence.

The foregoing enumeration is not intended as an exhaustive list of the factors taken into account by courts in determining the nature of the duty owed by a physician to his patient to make disclosure of collateral hazards. They are illustrative, however, of aspects of the case on which it would be appropriate for counsel to introduce evidence. They suggest reasons why a physician's duty will vary greatly from one case to another. For the purposes of this discussion they underscore the point that when the basis of the case is medical negligence as opposed to battery, the physician has a much wider range of discretion and the elements weighed in evaluating his conduct are more numerous. These authorities warrant the conclusion that when a physician tells a patient what he proposes to do, he has a strict duty to explain the nature and character of the procedure in terms that the patient can understand, but that when the physician is considering whether he should disclose collateral hazards to the patient he may take into account many things other than the plain use of language. This conclusion has important implications in subsequent litigation. A physician sued in a battery case has relatively little "elbow room" in which to establish a defense. A physician sued for medical negligence in failing to disclose hazards has many more possibilities on which to base a defense under the circumstances that existed. Herein lies one of the significant practical reasons why the distinction suggested at the outset of this paper should be kept intact.

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63. 159 So. 2d 888 (Fla. 1963).

64. 51 Del. 554, 149 A.2d 749 (Sup. Ct. 1959).

B. *Proof of Wrongful Act*

The crucial issue in a large percentage of cases involving physicians' professional liability is whether testimony by medical experts is required to establish the defendant's wrongful act. Decision of this issue frequently decides the lawsuit. It is in this connection that the distinction between battery and medical negligence may be of controlling significance.

1. Battery Cases

In the battery cases, as indicated above, the factual issue is quite simple. Did the physician, by the words he spoke, or by his failure to speak, or by his incomplete statement, or by his failure to explain written words, leave the patient with a substantial misunderstanding as to the general nature and character of the touching which the patient was to undergo? This is not a technical problem. It is not an issue which requires expert knowledge. It involves no more than an understanding of English and its usage plus the ability to assess the effect certain words might have or the meaning to be derived from certain expressions.

Some of the cases already mentioned illustrate the point. In *Bang*,[65] the case in which plaintiff submitted to a prostate operation in the course of which defendant surgeon, as a part of the operation, severed and tied off the spermatic cords thereby rendering plaintiff sterile, the issue was whether plaintiff had ever been informed by defendant that severance of his spermatic cords was part of the operation. Defendant could not recall definitely whether "that particular detail of the operation was discussed with Mr. Bang or not." Here it is obvious there was no need to bring in an expert. This was not a matter of a collateral "hazard" or "risk" of an operation that might or might not develop. It was apparently a planned part of the procedure. It might have been a "detail" to the physician, but it surely would be deemed an important one by most people. The issue is not whether the physician *should* have told the patient about it. The issue is whether the physician *did* tell the patient about it. Plaintiff's testimony was that he was not told about it. Twelve non-medical people can decide that issue without outside help just as reliably as they can decide a simple sales case, where the question is what statements the parties made or did not make to each other.

Similarly, in *Corn*,[66] the case involving the mastectomy, the evidence suggested that plaintiff was not familiar with the word, that defendant physician did not explain it, that their oral exchange had indicated to her that he was not going to remove her breast, and that she repeatedly said she did not want it removed. Here again there is no necessity for

65. See note 39 supra and accompanying text.

66. See note 46 supra and accompanying text.

expert evidence. Any jury of intelligent laymen can understand the dispute and make a reasonably reliable judgment as to whether Mrs. Corn did or did not consent to have her breast removed.

Some cases may not be as open and shut as the two last mentioned. For example, in *Paulsen v. Gundersen*,[67] the surgeon described the procedure he intended to perform as a "simple" mastoid operation; actually what he performed was a "radical" mastoid operation. While it is not quite as clear that laymen may be left to their own judgment here, one can understand a court holding that the case does not necessitate expert testimony. The ultimate issue is whether the operation performed was in substance the same as or different from the operation to which consent was given. While an expert might be needed to describe the difference between the two procedures, the ultimate question whether plaintiff *understood* the difference and comprehended what he was about to undergo is basically a question for lay judgment. Similarly, in *Wall*,[68] the case involving the cyst in the neck, the decision was whether the procedure defendant ultimately engaged in was substantially the same as that which he described to plaintiff. This is one that is surely within the competence of laymen in appraising the meaning of language and the manner in which ordinary English words are understood by ordinary people.

To repeat, the essential question in this kind of case is not whether defendant *should* have told plaintiff what he was going to do; it is whether he *did* tell plaintiff what he was going to do. The law gives plaintiff a right to know what kind of a touching he is to undergo. The decision for the jury is whether defendant conveyed an adequate impression of what was intended. On this question expert evidence serves no useful purpose.

2. Medical Negligence Cases

When we turn to medical negligence cases, proof of defendant's wrongful act presents quite a different problem. The question is not whether defendant conveyed a clear impression of the nature and character of the intended touching. It is assumed he did so. The question is whether defendant violated his obligation to the patient to describe *collateral* consequences that might ensue as a result of the intended and permitted touching, or from some other source such as the healing process.

As early as 1959 there was a clear recognition in the Superior Court of Delaware that the question whether a physician should warn a patient of collateral hazards attendant upon a medical procedure is a medical question on which lay judges and juries are not competent to make a decision. The case was *Fischer v. Wilmington General Hospital*,[69] in which

67. 218 Wis. 578, 260 N.W. 448 (1935).
68. 138 F.2d 478 (5th Cir. 1943).
69. 51 Del. 554, 149 A.2d 749 (Sup. Ct. 1959).

plaintiff contracted hepatitis as a result of a transfusion of whole blood. The propriety of the transfusion was not seriously questioned, but plaintiff and her husband based their claim upon the failure of defendant to advise them of the danger of contracting hepatitis. As indicated above,[70] affidavits filed by defendant indicated that the risk of contracting hepatitis, while unavoidable, materialized in less than one percent of such transfusions. One of the affidavits of a local physician, however, also contained the following statement: ". . . it is not my practice or the practice generally within the medical profession in this locality to advise patients of the risk of such infection, since the psychological and psychosomatic effect of the alarm which would be produced by such advice would run counter to the beneficial effect sought to be produced by the transfusion itself."[70a]

On the basis of the foregoing statement, which was undisputed, the court held that no jury question was presented and defendant's motion for summary judgment dismissing the complaint was granted.

Thus, before *Natanson* in Kansas, there was this record in at least one of the appellate courts of the country that on this essentially medical problem expert evidence was relevant and could be controlling. While both the *Salgo* and *Natanson* opinions may have recognized this principle by implication, neither opinion set forth an unambiguous indication of the need for expert evidence.

In a 1961 case, the Supreme Court of Delaware approved the principle. Plaintiff underwent a thyroidectomy in the course of which she suffered an injury to the recurrent laryngeal nerves which caused a substantial loss in her vocal power. No negligence was found in the procedure by the surgeon but the claim was based largely on the theory that she had not been warned that this injury was a hazard of this type of surgery. Defendant's counsel introduced medical testimony which was unanimous that: "it was not the practice of surgeons in the Wilmington area to warn patients of the possibility of resultant injury to the recurrent laryngeal nerves from a thyroidectomy."[71] The court held that as this evidence was undisputed it followed that there was no duty imposed upon defendant to warn plaintiff of the possibility that she might suffer the injury.[72]

The requirement of expert medical evidence is carried even further by a substantial line of cases holding that the absence of evidence showing

70. See note 64 supra and accompanying text.

70a. Id. at 561, 149 A.2d at 753.

71. Difilippo v. Preston, 53 Del. 539, 550, 173 A.2d 333, 339 (Sup. Ct. 1961).

72. See also Woods v. Pommerening, 44 Wash. 2d 867, 271 P.2d 705 (1954). In Ball v. Malinkrodt Chem. Works, 53 Tenn. App. 218, 381 S.W.2d 563 (1964), in which judgment for defendant based on a jury verdict was affirmed, the court approved an instruction that gave the physician broad leeway in determining the extent to which he would warn the patient of the potentially dangerous results of a translumbar aortogram.

a practice to warn requires a *directed verdict or a dismissal* of the action.

One of the first such cases appeared in 1962. Plaintiff underwent a vein stripping operation by defendent. She claimed he used more incisions than she had been led to believe would be used (which he denied) and that he had failed to advise her that there would be scars and disfigurement on the leg. The court made several statements which indicated that it regarded the latter claim as a question for expert testimony. For example:

> But, how a physician chooses to discharge his obligations to a patient involves primarily a question of medical judgment. . . . [W]hether or not a surgeon is under a duty to warn a patient of the possibility of a specific adverse result of a proposed treatment depends upon the circumstances of the particular case *and upon the general practice followed by the medical profession in the locality; and the custom of the medical profession to warn must be established by expert medical testimony.*[73]

There have been at least two cases in Michigan in which a similar view has been taken. One was in the Supreme Court in 1963. It was *Roberts v. Young*,[74] in which plaintiff brought action against a physician because of infection in the abdomen following a Caesarean operation and the ligation of her tubes. No evidence was adduced to show negligence in the performance of the operation. It was suggested by counsel for plaintiff that a possible basis for liability was that the physician had failed to disclose to plaintiff the danger of an infection following this kind of operation and procedure. At the end of plaintiff's case, defendant moved for a directed verdict; the trial judge granted the motion and gave judgment for defendant. The Supreme Court affirmed and with respect to the matter of failure to warn made the following statements:

> The question presented is in substance whether a physician and surgeon before operating should advise the patient of all *possible* results. Whether such should be done would seem to be a matter to be determined with reference to the general practice customarily followed by the medical profession in the locality. . . . As before indicated, whether such possibility should have been discussed with the patient is a matter to be determined in accordance with the general practice customarily observed by practitioners in good standing of defendant Young's school of treatment.[75]

In *Miles v. Van Gelder*,[76] plaintiff suffered injuries as a result of a myelogram to confirm findings indicating a ruptured disc. In the suit that

73. Govin v. Hunter, 374 P.2d 421, 423-24 (Wyo. 1962) (emphasis added).

74. 369 Mich. 133, 119 N.W.2d 627 (1963).

75. Id. at 140, 119 N.W.2d at 630. In some cases courts have expressly disavowed any requirement that a physician advise the patient of all possible risks. In Bell v. Umstattd, 401 S.W.2d 306, 313 (Tex. Civ. App. 1966) the court said, "It would, indeed, be unreasonable and undesirable to place a burden of full and complete disclosure upon each and every specialist involved as to the specific methods intended to be used in an operation and all of the possible risks involved in each step of an operation." See also Valentine v. Kaiser Foundation Hosps. 194 Cal. App. 2d 282, 15 Cal. Rptr. 26 (1961).

76. 1 Mich. App. 522, 137 N.W.2d 292 (1965).

followed, one of the allegations was that defendant failed to advise plaintiff of the reasonable expectations of risk and harm from the procedures so that plaintiff was given no opportunity to make a reasonably informed choice. In that connection the court referred to the *Roberts* case cited above and pointed out that this allegation could not be the basis for a recovery because "there is a complete lack of medical evidence as to the standard of practice followed by practitioners in the community on advising a patient of reasonable expectations of risk and possibility of harm from the operation proposed."[77] Similar holdings appear in Iowa and Florida.[78]

Like all questions of fact, however, this one may be decided as a matter of law under appropriate circumstances. Such a decision is usually warranted when there is no substantial dispute in the evidence and when the inference to be drawn is so clear that reasonable minds could not differ. For example, in the *Natanson* case, second opinion,[79] the court indicated that if it were found that Doctor Kline did not say anything at all to Mrs. Natanson about the hazards of irradiation, he "failed in his legal duty . . . *as a matter of law*."[80] In view of the circumstances of that case there is nothing very shocking about that position. A similar approach, but with the opposite result, appears in *Roberts v. Wood*.[81] Plaintiff, who had had a thyroidectomy some years previously, underwent a second. The recurrent laryngeal nerves were injured and plaintiff lost much of her voice. One of her claims of negligence was that she had not been sufficiently advised as to the seriousness of the operation. The evidence showed that defendant had told her that the operation would be similar to the prior one, that she was an emotional person suffering anxiety, apprehension and fear and that the physician took this mental or emotional state into account in determining the extent to which he should refer to the dangers of the operation. The court held as a matter of law that the physician's duty of disclosure had been fulfilled.[82]

An interesting variation appears in *Block v. McVay*.[83] The physician gave the patient information about the prospective operation, but he had made a mistake in diagnosis. He thought that he was dealing with a tumor in a lymph node and told plaintiff the operation was a "simple, ordinary and frequently performed procedure." As the operation progressed he

77. Id. at 532, 137 N.W.2d at 297.

78. Grosjean v. Spencer, 140 N.W.2d 139 (Iowa 1966); Ditlow v. Kaplan, 181 So. 2d 226 (Fla. App. 1965).

79. 187 Kan. 186, 354 P.2d 670 (1960).

80. Id. at 189, 354 P.2d at 673.

81. 206 F. Supp. 579 (S.D. Ala. 1962).

82. See also Hunt v. Bradshaw, 242 N.C. 517, 88 S.E.2d 762 (1955).

83. 80 S.D. 469, 126 N.W.2d 808 (1964).

found it was a neurofibroma, a benign nerve tumor. Its removal was a much more serious procedure. In the course of doing it, some minute nerve fibres were severed as a result of which plaintiff suffered numbness of her right arm and thumb. Plaintiff claimed that she had not been properly advised of the hazards of the operation. The court found that there was no negligence in making the erroneous diagnosis and that, on the basis, of it defendant had fulfilled his obligation to the patient in telling her that the operation was a simple one. A directed verdict for defendant was affirmed.

In a case in which the court decides the issue for plaintiff as a matter of law, it is possible for a hasty or unsophisticated reader to conclude erroneously that the court is treating the case as if it were one of battery, especially if the opinion does not make the distinction entirely clear. The decision is capable of being misconstrued as a holding that expert evidence is not required on the issue of "informed consent." This is what seems to have happened in *Natanson* and, as we shall see below, seven years later the Kansas Supreme Court is still explaining what it meant in those opinions.[84]

Another type of case that has potential for confusion is one in which the standard practice of disclosure is established but where there is a conflict in the testimony as to whether the physician made the required disclosure. Here again no expert evidence is required. The jury is capable of determining unaided which side it will believe. An example is *Wilson v. Scott*.[85] The standard of disclosure, which was established by defendant's own testimony, was that in the case of a stapedectomy it was the practice to advise the patient that he had an 89 per cent chance of achieving good hearing in the ear following surgery, a 10 per cent chance of no increase in hearing and a 1 per cent chance of a loss in hearing. Plaintiff suffered a loss in hearing. The defendant surgeon testified that he had advised the patient exactly in the manner described. The patient denied that he had been so informed. The court held that in these circumstances there was no need for expert testimony, and that the case should be tried on that basis. The *Wilson* case ought not to cause confusion, however, because the opinion of the majority makes perfectly clear what it holds and the point is driven home by a dissenting opinion.

It is interesting to observe that, in the years that have followed the *Natanson* and *Mitchell* opinions, both the Kansas and Missouri Supreme Courts have made efforts to rectify the deficiencies of those opinions and to align the law with that of other jurisdictions in the United States. The

84. See, e.g., Collins v. Meeker, 198 Kan. 390, 424 P.2d 488 (1967).

85. 412 S.W.2d 299 (Tex. 1967). The decision in the intermediate appellate court (396 S.W.2d 532 Tex. App. 1966) is the subject of a well-considered note in 44 Texas L. Rev. 799 (1966).

first of these efforts came in Kansas. A three-year-old boy with a congenital heart condition underwent cardiac catheterization. In the course of it, the child awakened from the anesthetic and started struggling; 100 milligrams of sodium pentothal were injected into his bloodstream through the heart catheter. Within 20 seconds his heart rate slowed and his blood pressure was not obtainable; a few hours later he died. Suit was brought on the theory that although the parents realized that there was some danger in the operation they had not been fully informed of the hazard that had developed. The testimony of one of the experts was that there was some risk in the use of sodium pentothal. The Kansas Supreme Court responded as follows:

> Notwithstanding the complete disclosure on the part of the defendant doctors, plaintiffs offered no evidence of what a reasonable physician would do under like and similar circumstances . . . . The evidence clearly shows that plaintiffs were informed of the nature of the procedure and of the things the doctors were undertaking to do. They had the facts upon which to base their decision, and we are of the opinion the parents were fully informed. The record is devoid of any standard of care required of the defendant doctors, much less any violation of such standards, known or unknown.
>
> The evidence introduced by the plaintiffs was wholly insufficient to establish a case of liability against any of the defendants. It also was insufficient to permit a jury to speculate as to what the defendants should or should not have done.[86]

The court then distinguished the *Natanson* case, stating there was no deviation from the rules laid down there.

Another effort to explain *Natanson* involved a plaintiff who underwent surgical treatment of a hernia by two doctors in two different operations, with harmful results. He sued both physicians and, among a number of other charges, asserted that each had failed to inform him of the risks inherent in the hernia operation which he had performed. Reliance was placed on *Natanson*. In the course of the opinion the court explained the *Natanson* result as follows:

> What we believe does need to be stated at this point is that in *Natanson* this court held, in practical effect, that in the absence of an emergency, a physician has an obligation to make a reasonable explanation and disclosure to his patient of the risks and dangers which inhere in a proposed course of treatment (and, we may add, in a proposed operation) to the end that whatever consent the patient gives to the prescribed treatment (or operation) may be an informed and intelligent consent; that where a physician, or surgeon, is silent and makes no disclosure whatever, he has failed in the duty owed to his patient and the patient is not required to produce expert medical testimony to show that the doctor's failure was contrary to accepted medical practice, but it devolves on the doctor to establish that his failure to make any disclosure did, in fact, conform, under the confronting conditions, to accepted professional standards; and that where actual disclosures have been made and are ascertainable, then expert medical testimony is required to establish that the dis-

86. Williams v. Menehan, 191 Kan. 6, 10, 379 P.2d 292, 295 (1963).

closures made did not accord to those which reasonable medical practitioners would divulge under the same or like circumstances.[87]

After referring to its 1963 statements in *Williams*, the court continued its explanation of *Natanson* as follows:

At no time has this court ventured to say that a physician or surgeon is under obligation to disclose any and all results which might possibly follow a medical or surgical procedure. Nor would we now deny that there may well be circumstances under which it would be bad therapeutic practice to disclose the nature, the procedures and the possible harsh results of treatment. Even though a patient may be relieved of the burden of showing, by expert evidence, that his doctor's silence deviated from acceptable medical practice, there is nothing in this rule which would preclude the doctor, himself, from showing that his silence did, in fact, comply with medical standards under the facts then facing him. We continue to believe that the principles enunciated in *Natanson* are valid.[88]

The court then examined the evidence in the cases before it and found that one physician made no disclosure of adverse effects that might follow a hernia operation, whereas the other had done so and had asked the patient whether he had any questions. On this basis it was held that the *Natanson* rule applied to the first physician and did not apply to the second. A summary judgment in favor of the first physician was reversed on this ground. As a tentative generalization, therefore, it appears that in Kansas at the present stage of evolution of the *Natanson* progeny, a physician must say *something* in the way of warning to remove the curse of the *Natanson* case; but when he has done so, the issue of whether he has gone far enough is recognized as a question on which expert testimony is required.

In Missouri, in late 1965, the Supreme Court repudiated the broad dictum that had appeared in the *Mitchell* opinion. The case was *Aiken v. Clary*.[89] It also involved an injury from insulin-shock therapy during which plaintiff lapsed into a coma and suffered organic brain damage resulting in total disability. The case was tried on a theory of negligence in failing sufficiently to advise plaintiff of the hazards. The jury returned a verdict for defendant. On appeal, the court recognized that the real issue was whether the plaintiff would be required to present medical testimony as to a standard to be followed in making disclosures of collateral risks. It reviewed that *Mitchell* case, and, after stating that a division of opinion existed in the country, it made the following statements:

We have reexamined this question and have concluded that the question of what disclosure of risks incident to proposed treatment should be made in a particular situation involves medical judgment and that expert testimony thereon should be re-

87. Collins v. Meeker, 198 Kan. 390, 396-97, 424 P.2d 488, 494-95 (1967).
88. Id. at 397, 424 P.2d at 495.
89. 396 S.W.2d 668 (Mo. 1965).

quired in malpractice cases involving that issue. The question to be determined by the jury is whether defendant doctor in that particular situation failed to adhere to a standard of reasonable care. These are not matters of common knowledge or within the experience of laymen. Expert medical evidence thereon is just as necessary as is such testimony on the correctness of the handling in cases involving surgery or treatment. . . . The question is not what, regarding the risks involved, the juror would relate to the patient under the same or similar circumstances, or even what a reasonable *man* would relate, but what a reasonable *medical practitioner* would do. Such practitioner would consider the state of the patient's health, the condition of his heart and nervous system, his mental state, and would take into account, among other things, whether the risks involved were mere remote possibilities or something which occurred with some sort of frequency or regularity. This determination involves medical judgment as to whether disclosure of possible risks may have such an adverse effect on the patient as to jeopardize success of the proposed therapy, no matter how expertly performed. (Defendant in this case testified that plaintiff was "real shook.") After a consideration of these and other proper factors, a reasonable medical practitioner, under some circumstances, would make full disclosure of all risks which had any reasonable likelihood of occurring, but in others the facts and circumstances would dictate a guarded or limited disclosure. In some cases the judgment would be less difficult than in others, but, in any event, it would be a medical judgment. In malpractice cases involving surgery or treatment the fact that the procedure or the operation is simple, rather than difficult and complex, does not eliminate the requirement that a plaintiff offer expert testimony that the procedure followed constituted a failure to use that degree of skill and learning ordinarily used under the same or similar circumstances by the members of defendant's profession in good standing practicing in similar localities. Plaintiff would be required to offer such expert testimony in order to make a submissible case. Likewise, in our judgment, it is not possible in cases dealing with alleged failure to make adequate disclosure to say that there must be expert medical testimony in more serious cases as to what a reasonable medical practitioner would have done, but that such proof is not required in less complicated cases. Such a distinction is suggested in some of the writing on this subject, but we do not subscribe thereto. Accordingly, we hold that plaintiff, in order to sustain his burden of proof, is required to offer expert testimony to show what disclosures a reasonable medical practitioner, under the same or similar circumstances, would have made, or, stated another way, that the disclosures as made by the defendant do not meet the standard of what a reasonable medical practitioner would have disclosed under the same or similar circumstances. To whatever extent Mitchell v. Robinson, Mo., 334 S.W.2d 11, 79 A.L.R.2d 1017, is inconsistent with the views herein expressed, it is disapproved.

Once plaintiff has offered sufficient proof to make a submissible case, including the required expert testimony which we have discussed, then the ultimate determination of whether defendant did or did not fail to disclose to plaintiff in accordance with the standard of what a reasonable medical practitioner would have done is a jury question under proper instructions from the court.[90]

90. Id. at 674-75. That the Missouri Supreme Court still has a long way to go before it fully understands the general problem is indicated by the fact that it cites Woods v. Brumlop, 71 N.M. 221, 377 P.2d 520 (1962) for the proposition that some courts do not require expert testimony as to a physician's obligation to disclose collateral hazards. The Woods case did not involve this isue; it had been raised in the complaint but the court wrote: "[P]laintiff, at the trial and now, relies entirely upon her contention and allegation that the breach of duty

Because counsel, in reliance on *Mitchell*, had omitted to adduce expert testimony, the case at bar was sent back for a new trial.

Summarizing this portion of the discussion, it appears that the courts are approaching unanimity in the view that in a cause of action based on medical negligence in failing to disclose collateral hazards, expert evidence must be adduced to establish the standard against which to measure defendant's conduct. In Kansas, a physician's failure to make *any* disclosure in the face of a dangerous procedure casts the burden upon him to justify his failure and, in the absence of such justification, the issue will be decided against him as a matter of law. Perhaps judges in other states will find this approach appealing to their sense of justice. Whatever qualifications and refinements ultimately emerge, it is obvious that in this kind of "informed consent" case, plaintiff's counsel is confronted by a much different task than in the battery cases.

C. *Causal Relationship and Damages*

In the establishment of causal relationship and the determination of recoverable damages there are additional reasons for maintaining the distinction emphasized in this paper.

1. Battery Cases

The essence of the legal wrong to plaintiff in a battery case is the touching itself which, standing alone, entitles him to substantial damages.[91] Thus the issues of causation and damages are simple. All that need be shown is that what was done differed substantially from that to which consent was given. The cause of action is then complete. No case suggests that it is necessary to show that if the truth had been told plaintiff would have withheld consent.

The problem of the actual amount the jury may be allowed to award is not unique; it appears in many kinds of tort cases and its resolution involves conventional doctrines of damages and evidence.

2. Medical Negligence

In medical negligence cases, however, the issue of causation is more complex in theory and practice. Plaintiff must show that if he had been

was the failure of defendant to tell plaintiff the truth in answer to a direct inquiry as to the dangers that might result from such treatment, and upon plaintiff's reliance upon defendant's alleged statement that no harm could result to her from such treatment. The testimony is directly conflicting upon this question. . . . Under the circumstances of this case, a fact issue was presented for determination by the jury upon which there was no necessity for expert medical testimony." Id. at 226-29, 377 P.2d at 524-25. Thus, Woods was a fraud or deceit case and it is believed no one has ever claimed that expert testimony is necessary to establish a physician's obligation not to deceive the patient.

91. Lloyd v. Kull, 329 F.2d 168 (7th Cir. 1964) ($500 for unauthorized removal of a mole); Rolater v. Strain, 39 Okla. 572, 137 P. 96 (1913) ($1,000 for removal of a sesamoid bone from the foot).

fully advised as to the collateral risk he would not have submitted to the procedure. This is a sort of "but for" rule. There must be a cause-in-fact relationship between plaintiff's ignorance of the risk and his willingness to go forward with the operation. The converse is also true, i.e., if it appears that plaintiff knew of the risk all the time, the failure of the physician to disclose it would have no causal connection with the injury.

This principle was recognized clearly at the outset in the *Natanson* opinions. In the first opinion we find this recital: "There was evidence from which the jury could have found that the appellant fully appreciated the danger and the risk of the radiation treatment."[92] As to this element, the court said: "Under the rule heretofore stated, where the patient fully appreciates the danger involved, the failure of a physician in his duty to make a reasonable disclosure to the patient would have no causal relation to the injury."[93]

How is this causal relationship to be proved? It may not be difficult. All that plaintiff may need to do is testify that he would not have permitted the operation if he had known the risk; then, unless his veracity is impeached, or his assertion is inherently incredible (e.g., because of the slight danger involved), or there is proof that he actually knew of the danger all along, he would at least make an issue for the jury.

In *Natanson*, in the second opinion, the court went even further. It wrote: "While the appellant did not directly testify that she would have refused to take the proposed cobalt irradiation treatments had she been properly informed, we think the evidence presented by the record *taken as a whole* is sufficient and would authorize a jury to infer that had she been properly informed, the appellant would not have taken the cobalt irradiation treatments."[94]

Not all courts have been as generous with plaintiffs in permitting such an inference. In one case, plaintiff suffered a substantial loss of vision in her right eye alleged to have been caused by a hemorrhage following a cataract operation. The claim was based in part on failure to disclose the risk. A judgment for plaintiff was reversed, one of the grounds being that there was no testimony from plaintiff that she would not have submitted to the eye operation by defendant had she known of the risk inherent in it. On this point the court wrote:

> In this case, not only is there an absence of such proof, but facts in evidence tend to negate the causal connection. The fact that the plaintiff proceeded to have this operation upon her other eye by another surgeon, presumably after she was fully informed of the inherent risks to this operation, is some evidence that disclosure by the defendant of inherent risks would not have deterred her from having the earlier operation. The risks of injury are not so great as to cause most reasonable persons

92. 186 Kan. at 400, 350 P.2d at 1099.
93. Id. at 410, 350 P.2d at 1106.
94. 187 Kan. at 191, 354 P.2d at 673-74.

to decline to have such a beneficial operation performed, one that has such a good chance of restoring the sight of a substantially nonfunctional eye to an eye capable of 20/20 vision with the aid of a lens. The plaintiff's failure to testify on this subject is itself indicative to some degree. . . .

We believe that, if the theory of battery be inapplicable, the plaintiff failed to make out a case insofar as proximate cause is concerned, and the motions for a directed verdict and for judgment made by the defendant should have been granted.[95]

In some cases it seems to be suggested that there is a requirement that plaintiff produce evidence in addition to, or other than his own testimony that he would not have had the operation had he known the risk. In a case involving injury to laryngeal nerves during a thyroidectomy, plaintiff sought to testify that had she known the danger she would not have had the surgery. The North Carolina court approved exclusion of this evidence, stating:

The plaintiff attempted to testify that if the defendant had advised her the operation might involve paralysis of the vocal cords she would have withdrawn her consent. The court excluded this testimony which presented a case of looking backward. Perhaps the defendant with the benefit of a backward look would not have performed the operation; but at the time decision was made to operate the surgeon was dealing with a patient who had a diseased gland which failed to secrete the proper amount of hormone. The medical experts, plaintiff's witnesses, say surgery in such event is indicated. All cutting operations involve some risks. Possible dangers of an operation had to be balanced against the certain danger of a diseased thyroid. Decision had to be made before the operation. To permit the plaintiff to change the decision afterwards is equivalent to looking at the answer without solving the problem.[96]

However, a subsequent pronouncement of the North Carolina Supreme Court on this subject appears in *Sharpe v. Pugh*,[97] which involved a claim that defendant had breached his duty, *inter alia*, by failing to warn parents of a child patient that the use of chloromycetin might cause aplastic anemia. The case came before the Supreme Court on appeal from the granting of a motion to strike this and certain other portions of the complaint. The court considered whether the allegations relating to the failure to warn were a proper part of the entire cause of action. After holding that there was a duty to warn in view of the allegations in the complaint, the court said: "[A]nd it may be reasonably inferred from plaintiff's allegations that, if the facts concerning chloromycetin are as alleged by plaintiff, Brenda's parents would not have consented to or permitted the use of chloromycetin in defendant's treatment of her."[98]

Whatever subsidiary variations may develop in the future, the main

95. Shetter v. Rochelle, 2 Ariz. App. 358, 367, 409 P.2d 74, 83 (1965), modified, 2 Ariz. App. 607, 411 P.2d 45 (1966). Incidentally, the opinion of Judge Molloy in this case is one of the most perceptive and instructive that has come to the writer's attention.

96. Watson v. Clutts, 262 N.C. 153, 160-61, 136 S.E.2d 617, 622 (1964).

97. 270 N.C. 598, 155 S.E.2d 108 (1967).

98. Id. at 605, 155 S.E.2d at 113.

point in which we are interested at the moment is that in cases involving medical negligence plaintiff does not establish his cause of action merely by showing that the surgery or other medical procedure took place; it is essential for him to go further and establish the causal relationship between his injury and defendant's failure to disclose collateral hazards and risks. Once this causal relationship has been established, the question of what damages may be recovered is answered by application of the conventional doctrines of the jurisdiction on damages and evidence. In some cases, expert medical testimony may be required to establish the relationship between the surgery and the particular injurious phenomenon of which plaintiff complains. This is normal practice in personal injury actions, including those having nothing to do with professional liability.

D. *Statute of Limitations*

Another way in which the distinction between a battery action and a negligence action may make an important difference is in determining the applicable statute of limitations. In a substantial number of states the limitations period applicable to battery actions is different from that applicable to negligence actions,[99] including in the latter category, what are sometimes called in the statute, "malpractice" actions.[100] In about one-half of the states, the battery period is shorter than the negligence period.[101] Thus courts are often required to decide whether to treat a particular kind of allegation as setting forth a cause of action in battery or in negligence. Frequently, the claim relates to consent or lack thereof on the part of the patient. In this type of case there appears to be a strong inclination on the part of the courts to treat the action in such a way that the longer period applies. It is not difficult to understand this reaction.

An interesting example is found in a 1965 Oregon case. Plaintiff received a spinal anesthetic shortly before the birth of a child and became permanently paralyzed. She brought her action on a negligence theory alleging improper positioning, handling, placing and securing her for administration of the anesthetic. At the start of the trial, she asked leave to amend her complaint to alleged negligence in other particulars, includ-

99. It is stated by Louisell and Williams that 31 states and the District of Columbia have separate statutes of limitations pertaining to assault and battery. D. Louisell & H. Williams, Trial of Medical Malpractice Cases § 1304 (1966).

100. Whether the terms "malpractice" and "negligence" mean the same thing can be a troublesome question. In Gerba v. Neurological Hosp. Ass'n, 416 S.W.2d 126 (Mo. 1967), a hospital was sued for failure properly to attend and restrain an emotionally ill person who injured herself. The court applied a two-year statute of limitations which related to action against hospitals (and others) "for malpractice, error or mistake." It said: "We find it difficult to understand plaintiff's contention that there is a difference between 'ordinary negligence' and negligence relating to malpractice." Id. at 128.

101. See note 99 supra.

ing the following: "(e) In failing to procure plaintiff's consent prior to administration of a spinal anesthetic."[102]

The trial court "disallowed" the quoted amendment on the ground that it stated a new cause of action for assault and battery which was barred by the two years' statute of limitations period. The Supreme Court held this ruling erroneous. While acknowledging that the performance of a medical procedure to which there had been no consent, express or implied, is "a technical battery," the court concluded that an action in negligence for inadvertent failure to procure consent is an alternative remedy. In analyzing its precedents, the court said:

> The rule was applied by this court in Hively v. Higgs, 120 Or. 588, 253 P. 363, 53 A.L.R. 1052, where recovery as for a battery was sustained against a doctor who had been authorized by his patient to operate on the septum of her nose, but removed her tonsils while she was under an anesthetic. No negligence was alleged in that case. On the other hand, we held in Gill v. Selling et al., 125 Or. 587, 267 P. 812, 58 A.L.R. 1556, that a doctor who, due to a mistake in identity, performed a spinal puncture test on the wrong person was liable for negligence. This was a clear case of an unauthorized operation; though the failure to obtain the patient's consent was due to a mistake, the operation was nonetheless a technical battery and, no doubt, had the plaintiff so chosen, that could have been made the basis of recovery instead of negligence.
>
> Hively v. Higgs does not hold, as defendant contends, that the exclusive remedy for an unauthorized operation is assault and battery; the question was not presented.
>
> In our opinion the requested amendment alleging an unauthorized use of a spinal anesthetic did not state a separate cause of action for assault and battery, but merely an additional specification of malpractice. The amendment is cast in terms of negligence. Dr. Smith testified that it was the standard medical practice in the community to secure the patient's consent before administering a spinal anesthetic. Violation of that duty would be negligence or malpractice. "Malpractice, also sometimes called 'malapraxis,' means bad or unskillful practice, resulting in injury to the patient, and comprises all acts and omissions of a physician or surgeon as such to a patient as such, which may make the physician or surgeon either civilly or criminally liable." Herzog, Medical Jurisprudence, 153, § 180. The act of a physician in performing an unauthorized operation is referred to in the authorities as a *technical* battery. It does not necessarily involve the kind of willful and intentional conduct that this court dealt with in Denton v. Arnstein, 197 Or. 28, 250 P. 2d 407, where the defendant intentionally twice drove his automobile into the back of the plaintiff's automobile. Speaking with reference to that conduct we said: "An assault and battery is not negligence. . . . When defendant's conduct is wilful and intentional, it is no longer negligence. . . ." 197 Or. at 45, 250 P.2d at 415. But, if a physician should inadvertently (as in Shehee v. Aetna Casualty & Surety Co., 122 F. Supp. 1 (W.D. La. 1954)) fail to obtain the consent of his patient before performing an operation, the operation might constitute a technical battery, but it would still be a violation of the established standard of care and actionable as malpractice. See Natanson v. Kline, 186 Kan. 393, 402, 350 P.2d 1093; 187 Kan. 186, 354 P.2d 670.[103]

102. Mayor v. Dowsett, 240 Ore. 196, 231, 400 P.2d 234, 250 (1965).

103. Id. at 232-33, 400 P.2d at 250-51 (1965).

This approach seems fairly close to that suggested by Professor McCoid in his 1957 article,[104] and indeed the court cites his writing as authority for its view.[105] Other courts have reached similar conclusions, although not always on the same reasoning.[106]

For purposes of this article, it is not necessary to pursue these authorities at length. Suffice it to say, that here is another phase of the litigation in which counsel may find it a matter of great consequence to analyze carefully the basic nature of the cause of action and not allow himself to be misled by uncertain characterizations thereof.

III. CONCLUSION

> What's in a name? that which we call a rose
> By any other name would smell as sweet.[107]

If these words are taken to suggest that one ought to be moved by realities rather than labels, little objection will be raised. If, however, they mean to state a principle that names are not important in communicating and exchanging thoughts, the principle has very limited application. Certainly to a lawyer, whose main tools are ideas and words, names are of enormous significance when used to identify the abstractions which make up so much of the fabric of law. Inaccurate employment of names breeds confusion, sometimes calamity. The decade of "informed consent" turmoil since *Salgo* demonstrates the point.

At the time this is written most of the courts that have considered the categories of cases discussed in this article have come to recognize the realities involved, to penetrate the ambiguous term "informed consent," and to make the distinctions necessary for rational decision. Meanwhile, there has been waste of time and effort, as in *Aiken*,[108] where an entire trial was nullified because counsel had proceeded on a theory suggested by the Missouri Supreme Court, which was belatedly acknowledged by that court to be erroneous. Considering the body of authority that has come into existence, however, there can no longer be any excuse for failure by counsel to understand the legal issues as to the nature of the physician's duty, requirements for proof of breach of duty, and the causation and damages questions. Neither would there seem to be any excuse for the paranoiac alarm occasionally sounded by representatives of the medical

104. See note 8 supra.

105. 240 Ore. at 234 n.5, 400 P.2d at 251 n.5. The court's dictum probably goes further than Professor McCoid would, for it is not understood that he advocates alternative causes of action for inadvertent failure to obtain consent.

106. E.g., Maercklein v. Smith, 129 Colo. 72, 266 P.2d 1095 (1954).

107. Shakespeare, Romeo and Juliet, Act II, Scene I.

108. See note 89 supra and accompanying text.

profession that the "informed consent" rule has exposed them to inordinate burdens and unjustifiable liabilities.

There is still an element of uncertainty as to the statute of limitations to be applied in an "informed consent" case, if the state has separate statutes for battery and negligence. The cases involving this difficulty, however, are relatively rare.

It is instructive to note the manner in which the thoughtful suggestions made by Professor McCoid in his 1957 article were distorted to lead in exactly the opposite direction he contemplated. It is believed that he meant to say (and did say) that the range of assault and battery liability of physicians should be narrowed to embrace only those few cases in which a physician intentionally does actual harm to a patient and that liability for "malpractice" should be broadened to include the cases where there is inadvertent injury or invasion of rights, including unpermitted procedures as well as failure to advise the patient of collateral dangers. The latter development would mean that in many such cases, expert evidence would be required where it was not required before. For a time it appeared that his suggestion was being utilized to transform failure to give warning of collateral hazards into assault and battery liability in which, generally, no expert evidence is necessary.

It is not out of place to draw attention to the venerable principle that an appellate court ought to limit its decision (and opinion) to those issues that must be decided to dispose of the case at bar. The obvious reason is that a decision is much more likely to be wise and just if the issue has been thoroughly briefed and argued by counsel for parties who have sufficient personal stake in the outcome to prompt the best possible effort in presenting the opposing sides of the case. This worthy doctrine seems to have lost ground in some quarters during the past two decades. Rambling, discursive opinions are increasingly common. The evil that they do lives after them and underscores the soundness of the original precept.

One may be forgiven for yielding to the temptation to say also that some appellate judges in the country create the impression that they deem themselves heirs of the mantle of Cardozo and other judicial masters whose decisions are landmarks and whose opinions are literary gems. Unfortunately many of these imitators lack legal depth or literary endowment, or both. Their efforts are often garish and sometimes disastrous.

A famous legal scholar once wrote, "It is surprising how much may sometimes be discovered by reading the cases."[109] He probably meant that such study was a surer path to legal truth than abstract theorizing about what the law ought to be. But some discoveries that result from reading the cases are disconcerting ones. Our experience with "informed consent" contains more than its share of these.

109. Prosser, Business Visitors and Invitees, 26 Minn. L. Rev. 573, 611 (1942).